

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

VOL. XCIX. — THURSDAY, OCTOBER 31, 1878. — NO. 18.

LECTURES.

A CLINICAL LECTURE ON AN UNUSUAL CASE OF UTERINE FIBROID, WITH A LONG PEDICLE, AND GIVING RISE TO ABDOMINAL DROPSY.

BY PROFESSOR T. GAILLARD THOMAS.

GENTLEMEN, — This patient, whose name is Mrs. F., and who is thirty-eight years of age and a native of the United States, has been brought to us to-day by Drs. Cornell and Wood. The latter has written out the history of the case very carefully; but I think it will prove more interesting and profitable for us to get the principal points of it from the patient herself, in our usual manner. Before doing so, however, I will pause a moment to call your attention to the very great importance of carefully observing the *facies* of every patient that comes into your charge. Always look at the countenance the first thing, and not infrequently it will give you the diagnosis at once.

In the present instance it is not difficult to discover from the *facies* that the general health of the patient is greatly depreciated. But now to go on with our questions. How long have you been sick, Mrs. F.? "Three and a half years." What seemed to annoy you especially at first? "Pain and heat in the left side, low down." Anything else? "Pain in the back." Did you have any trouble with regard to your monthly periods at that time? "No, none at all." As time went on, did you notice anything else? "I found that there was a lump in the abdomen." How long is it since you first discovered that? "Three years."

Dr. Cornell tells me that this lump of which the patient speaks was a hard bunch, which could easily be detected by conjoined manipulation at the time when his attention was first directed to it. This tumor, which afterwards became as large as a man's head, gave rise to ascites, and this was so extensive that Dr. Cornell was twice obliged to resort to tapping. On each occasion he removed at least fourteen pounds of fluid, and, in addition, there was a good deal of it which leaked out afterwards and could not be estimated. There has been no loss of blood

¹ Reported by P. Brynberg Porter, M. D.

to account for the debility which is such a prominent feature of the case.

When I came to make a physical examination myself I found that the patient's abdomen was as large as that of a woman at the full term of utero-gestation. The line of dullness on percussion, I ascertained, was altered when the patient changed her position, and, on making palpation, I got a distinct wave of fluid. These two symptoms show conclusively that the fluid in this case is not inclosed in a sac, but constitutes a general abdominal dropsy. Just below the umbilicus, however, I detected a hard tumor of large size, which was so movable that it could be readily thrown from one side of the abdomen to the other, and pushed either up above the umbilicus or down into the pelvis. It appeared to be somewhat nodulated in character, and I will now endeavor by means of a diagram on the blackboard to convey to you some idea of its size, shape, and position. I think you will get a good conception of its movability if I compare it to an apple floating in a bladder half filled with water. As you can readily imagine, the apple thus situated would be much more movable than if the bladder were entirely filled with liquid.

Now comes the question, What is the nature of this tumor? And here, I am sorry to say, my assistants and I differ in an opinion. They believe that we have a case of malignant disease of the ovary, while I have been led to conclude that the tumor is really a uterine fibroid. The case is, then, a very important one from a diagnostic point of view. As I told you last week, a diagnosis is nothing but the deduction of logical conclusions from certain premises, these premises being the symptoms in any given case. But it is quite possible that from the same premises very different conclusions may be drawn, as is frequently the case among logicians; and from the same symptoms here, as you have seen, my assistants have come to a very different conclusion from that which I have arrived at. You can readily perceive, also, that the prognosis is greatly affected by the diagnosis formed; a prognosis, as I remarked before, being merely the prophecy in regard to any given case based on the probabilities noted in connection with it.

Now let me tell you a few of the reasons which led me to suppose the tumor was a fibroid of the uterus. In the first place, solid tumors of the ovary are exceedingly rare. The late Dr. Peaslee, in his admirable work on Ovarian Tumors, collected all the cases that he possibly could, and they are very few indeed, while one of those which he mentions as a case of mine I do not think was a tumor of the ovary at all, but, in all probability, a uterine fibroid with a long pedicle.

Again, solid tumors of the ovary are almost invariably malignant; and if this one had been of that nature, the patient would certainly not be in as good a condition as she is at present, if she were alive at all, —

which would be highly improbable. When you consider that the average duration of ordinary ovarian cysts before a fatal termination is reached is only three years, you can readily imagine how much worse the prognosis must be in a case of malignant disease of the ovary.

On the other hand, you may ask, How often do uterine fibroids give rise to abdominal dropsy? and my reply is, *Almost never*. But in the present instance, I cannot doubt, there is an exception to the general rule. In a case such as I now show you on the blackboard, where the fibroid growth is everywhere firmly attached to the uterus and really forms a part of its substance, abdominal dropsy never results. In such a case I would not dare to operate, because the tumor would be so intimately associated with the uterus that the removal of one would necessitate that of the other, and death would almost certainly ensue. But if the fibroid were of the character which I show you here, being attached to the uterus only by a long and slender pedicle, it would be exceedingly likely to cause abdominal dropsy. As a compensation, however, it could probably be removed with comparatively little risk to the patient.

This, in my opinion, is the true character of the tumor found in the present instance. If such is the case it is removable; and as the patient has consented to enter my service at the Woman's Hospital, I hope to be able to cure her completely. Unless operative interference is resorted to, however, the patient's condition will become more and more rapidly depreciated, and a fatal termination of the case may not be far distant.

EXAMINATION OF THE NEGRO THOMAS, WHO ARRESTS HIS HEART'S ACTION, AND PRETENDS TO THROW HIS HEART INTO THE ABDOMEN.¹

BY MIDDLETON MICHEL, M. D.,

Professor of Physiology and Histology, in the Medical College of the State of South Carolina.

THE subject of this report is a negro, perhaps thirty years old, of great muscular development, which has been exercised in certain directions to so remarkable a degree that voluntary control over and power in particular muscles make him an interesting object of study.

He first exhibits an extraordinary play of the abdominal muscles, which are made to contract, not simultaneously, as may be done by any one, but in separate layers, and in the several divisions of the recti, which are successively and violently contorted into vermicular contractions: slowly, then more rapidly, first from below upwards, then, reversing their action, from above downwards, producing rigid intumescences at one point and passive depressions at others, all of which is

¹ Read before the Medical Society, July 1, 1878.

repeated with increasing frequency and vehemence until the sum of these muscular acts culminates in a tetanic rigidity, which seemingly expresses the aggregate of the force of all the fibres of all the muscles in the abdominal walls. Resting from the fatigue obviously attendant upon this exertion, he now proceeds to exhibit his ability to displace the heart into some one region of the abdomen. This, which he considers to be his great feat, he apparently accomplishes as follows: He invariably bends the body forwards to a greater or less degree; takes a deep inspiration, not suspending the breath, but, on the contrary, maintaining the diaphragm as depressed as possible, by keeping up very imperfect movements of expiration; then he throws certain abdominal muscles into contraction, depressing the greater portion of the walls of the abdomen, while he bulges out the region or spot where he assumes the heart to have migrated. This effort, interrupting the normal play of quiet respiration, is not long sustained: during a brief period the ear in the præcordial region certainly discovers, at first, a disappearance of the heart's pulsations, though these are soon again detected most faintly under a marked recedence of this organ from its natural position; while over the abdominal projection a cardiac murmur, more distinctly audible, is soon replaced by a *bruit de souffle*, which he voluntarily intensifies by periodic accelerations, as though this sound were due to the play of muscular action, being not unlike the well-known muffled sound induced by muscular fibres while contracting.

His next performance consists in arresting the heart's action and the pulse at the wrist, — a phenomenon well understood by physiologists ever since the case of the Hon. Colonel Townshend, and which your reporter has seen more completely accomplished, perhaps, by others than by this individual. Here, again, he takes a very deep inspiration, but on this occasion suspending his breath completely, — a most necessary condition for the successful accomplishment of his purpose, — when all cardiac pulsation ceases, and the pulse-wave is no longer felt at the wrist.

His particular achievements, then, consist in repetitions of these three acts, abdominal muscular contortions, displacement of the heart, and temporary suspension of its action, the true nature of which we must now investigate, though we at once anticipate the conclusions of this report by stating that his performances resolve themselves into a display of unusual muscularity and muscular tension only. That such is the proper explanation we shall now endeavor to show.

This man is well developed; an athlete in form, there is no malformation discoverable. While breathing naturally the normal movements of respiration are seen, while in forced respiration the play of a perfect diaphragm becomes evident in the ascendancy of abdominal over costal respiration. There is no fissure of diaphragm; indeed, the violent play of abdominal muscles just described, which habit and practice have ren-

dered truly extraordinary, with such a deformity present, would drive the viscera either from abdomen into thorax, or from the chest into the abdomen, and render any such performance painful, dangerous, and perhaps wholly impossible. The presence, therefore, of this perfect septum between thorax and abdomen makes it impossible that the heart could leave the thoracic cage. We reject the assumption of a migration of the heart from its normal position to various parts of the abdomen, whither he pretends to convey it, because we have ascertained the presence of a perfect diaphragm, and not upon theoretical preconceptions of the impossibility of a translation of this organ from the thorax to the abdomen through a fissure of the diaphragm. That he effects something in this attempt is positive; that he simulates very wonderfully a displacement of his heart is evident; but the explanation of the phenomenon he presents rests upon physiological and not pathological conditions, as we shall see.

Experimental research has shown that during forced inspiration the heart, under ordinary circumstances, is not only depressed, but changes its position; its point is directed towards the median line, and deviated still more conspicuously in this direction as the lung becomes more and more inflated and presses upon it, so that it may finally assume an almost vertical direction; it loses entirely its relation to the intercostal space between the fifth and sixth ribs, receding more and more from the walls of the chest, until its beat is no longer perceived in its normal situation. This descent of the organ may usually be carried to the extent of from three to five inches. It must be remembered that we are not speculating upon this subject. The effects of inspiration in retarding, and of expiration in accelerating, cardiac action belong to the daily teachings of the physiologist; but the change of the heart's whole position, this dislocation of the heart, so to speak, during inspiration, is not so familiar to every one, and was comparatively unnoticed until the researches of Professor Da Costa,¹ of Philadelphia, who made a series of observations on healthy persons, having first ascertained the "extent of percussion dullness of heart, and the normal position, and strength of the impulse of quiet breathing." A careful tabulated statement shows when the first sound, then the second, and finally both beats and the impulse wholly disappear in the præcordial region, while these become successively audible in the epigastrium below the ensiform cartilage. Direct experiment on the cadaver, in which Dr. Da Costa was aided by Dr. Agnew, showed that the inflated lung rose more and more until it reached the ribs, pressed upon the heart whose apex turned inwards, was lowered, and came distinctly forwards.² The descent of the diaphragm also influences the position of the heart

¹ Am. Journ. Med. Sc., January and April, 1859, pages 119 and 370.

² Am. Journ. Med. Sc., April, page 373.

through the connection of the pericardium with that muscle and with the aorta and pulmonary arteries, the result of which is to lengthen these eminently elastic vessels, and thus to lower the whole situation of the heart, though not to turn its apex inwards, which latter change is effected by the lung. The simple elevation of the walls of the chest cannot explain or account for the recognized change of position, which appears referable to the conjoined action of lung and diaphragm.

Now it is reasonable to suppose that in this individual the diaphragm in its extraordinary exercise has participated in development with the abdominal muscles, and is under such control that during an inspiratory effort of this exaggerated character he forces his heart even beyond the ascertained extent of depression in ordinary individuals, which would place it some six to seven inches below the ensiform cartilage, particularly as he is aided by the flexion of the body, with which he is careful always to accompany the act; this would remove the heart wholly beyond the reach of immediate auscultation at the normal point, and make it beat *apparently* within the abdomen, though still resting upon the floor of the preternaturally depressed diaphragm. As this muscular tension seems to be as painful as it is difficult, we find that it is of no long duration, and we have distinctly discovered that while he releases himself from the diaphragmatic tension, and the heart is again recognizable *in situ*, he can, at will, produce the soufflé sound in the abdominal point where it was supposed to have been, and with propulsive contractions simulate its return to this spot. The explanation of this supposed dislodgment of the heart certainly rests upon the exaggerated play of lung and diaphragm, and upon nothing else.

Did any abnormality exist, such as fissure of the diaphragm, the case would be somewhat complicated, for it would be difficult to limit the extent of displacement to which an organ might be liable under such a vice of conformation, though thus much may be said: that were this displacement of the heart to occur even as a hernia of the diaphragm it should have to take place during the *relaxation* of this muscle while the fissure was open, displaying its greatest capacity, and not during a contraction which necessarily would bring the margins of the fissure in rigid proximity, and tend to close it. Now, it is worthy of note that when he prepares to make the effort of displacement, he, on the contrary, always takes a forced inspiration and flexes the body; in other words, enforces such conditions as would obstruct or prevent rather than favor his proposed design. It must not be argued that the tension of vessels and nerves would be so great, under a transfer of the heart to the abdomen, that circulation would be impossible, and life itself be compromised, since in malformations of this kind these structures undergo a remarkable degree of adaptiveness.

Displacements of the heart contingent upon malformations are nu-

merous and varied, forming more than one group in the classifications of teratologists, and are of particular interest and importance in medico-legal questions concerning the viability of the child. Ectopia cordis, with arrest of development of the walls of chest and abdomen, invariably accompanied with absence of pericardium, is incompatible with viability; so is the upward cervical dislodgment of the heart found in connection with the base of the tongue, and placed vertically between the ununited halves of the lower jaw, reminding us of the permanent condition among fishes, and the embryonic mammalian stage of development. Even congenital perforations of any extent are accompanied by such other arrests of development as result in nothing short of a monstrosity; and though we here announce an organo-genetic law, yet the expected exception to this, as to every other rule, is to be found precisely in cases of perforation of the diaphragm; for extensive breaches of continuity in this muscle have been observed when no other sign of imperfection existed, and no knowledge of the abnormality was suspected throughout adult life until revealed by necropsic examination. Where no external arrest of development obtains, and even in the absence of all visible signs of deformity, the downward dislodgment of the heart into the abdomen through a fissure of the diaphragm is neither unknown to teratologists nor incompatible with perfect adult life, two examples of which I will adduce as specially interesting in this connection:—

Ramel, just one hundred years ago, in 1778, published the case of a girl, ten years old, whose heart was clearly recognized by him in the epigastrium; and as she was subject to frequent palpitations, this malposition of the heart might have impressed one with the belief in an aneurism at that point. This case, mentioned by Geoffroy St. Hilaire, is to be found in the old *Journal de Médecine, Chir., et Pharm.*, vol. xlix., page 423. The other case is recorded by Deschamps — *Observation sur un Déplacement remarquable du Cœur* — in the *Journal général de Médecine*, vol. xxvi., page 275. An old soldier was discharged from the service in consequence of a renal disease from which he had long suffered. Upon his return to civil life he married, and had children, but finally succumbed to his old complaint. At the autopsy an unexpected revelation occurred, as nothing of the kind had ever been suspected: a fissure of the diaphragm existed, and the heart was found in the left lumbar region, whilst the large vessels from its base coursed upwards through the opening to the lungs specially, and to their other destinations.

Among such anomalies of development, morphological changes in the great organs of circulation compatible with life would appear to be without limit. Such facts in science must make one cautious in immediately declaring that no ejection of the heart is possible under any

circumstances; they would almost invite credence in such a case as was ascribed to the celebrated Baudelocque, many years ago, in the thirty-fourth volume of the *Dictionnaire des Sciences médicales*, page 221, in which both an abdominal and thoracic heart were supposed to have been discovered by the distinguished French obstetrician in the same individual.

The suspension of the heart's action, and of the head-wave in the blood current which forms the pulse, has been so perfectly verified in several instances that we might pretermit all consideration of this question so far as it relates to this man, but that he adds to the annals of science another authenticated instance of the kind.

The case of the Hon. Colonel Townshend comes to us through one of his physicians, Dr. George Cheyne, author of a *Treatise on Nervous Diseases*, who was called with Dr. Baynard to see this gentleman at the Bell Inn, upon his arrival at Bath from Bristol. At one of their visits, while Mr. Skrine, the apothecary, was present, the colonel stated that he could *die* or *expire* when he pleased, and yet by an effort he could come to life again, and asked an explanation of the phenomenon; but as he was weak and sick, these gentlemen with reluctance assented to his making the trial. While he prepared himself for so strange an exhibition Dr. Cheyne held the pulse, Dr. Baynard examined the heart, and Mr. Skrine placed a mirror to the mouth; the pulse sank until it could not be felt, all motion of the heart ceased, and not the least soil of breath on the bright mirror was detected. Then each in turn examined the arm, heart, and breath, but could not discern the least symptom of life. He remained in this condition for a *half hour*, when the functions of respiration and circulation were gradually reinstated.

Some years ago I was invited by Professor Frost, then dean of the medical college of Charleston, to meet the faculty by appointment to examine a Mr. Grew, in whom there was an arrest of development of the sternum. Besides many interesting facts concerning the play of the heart, which were readily determined through the simple integumental covering which alone separated us from that organ, we had an opportunity of witnessing a like experiment upon the suspension of this heart's action and subsidence of the pulse. When he took a deep inspiration and then held his breath, the pulse grew weaker and weaker, and finally stopped entirely, while the ear over the præcordial region could not detect the slightest impulse or sound. The heart had ceased all action, and there was temporarily no pulse throughout the system.

Now this negro performs the same act, though not so prolonged in duration as in the case of Mr. Grew, in whom the experiment lasted almost two minutes, and he does it in the same way.

This most singular power, which from time to time has been possessed by certain trained individuals, is more than a matter of simply

curious interest to physiologists. In an analysis of the phenomena involved in its explanation, it appears to me to aid in unraveling those yet more wonderful occurrences known and spoken of as "states of trance," in which all evidences of life depart, and persons have even submitted to being buried for a time; while we are seemingly taught again that what may thus be brought about by an act of volition is but an imitation of that cataleptic state that ensues when the same centres of volition are in a pathological condition.

The obstruction to the circulation in this man's case is mechanical, depending upon the suspension of his breath. The illustrious Hunter could control his heart's action by interrupting his breathing until the former would almost stop its contractions. We are fully aware that the heart possesses an autocratic biotic force, and pulsates when removed from the body; but, like all other muscles, if injured by a blow or by attrition of its fibres or over-distention of the same, it for a time becomes paralyzed, and its rhythmic autocratic movements cease. Now, when the breath is held, the unaerated blood is obstructed first in the capillaries, then in the arterial system, and finally the systemic heart becomes distended enormously, and incapable of emptying itself. If this distention increases, rhythm first disappears, pulsations become feeble, and in a few seconds all contractions cease. The obstruction commences in the capillaries, and not in the lung; the accumulation of blood is in the arterial system; and the arrest of flow in the blood current is retrogressive. It is in this manner that a temporary interruption to the circulation and heart's action is effected by those who through practice have habituated themselves to endure a suspension of function not perhaps unattended with imminent risk to life if carried too far.

RECENT PROGRESS IN SURGERY.¹

BY J. COLLINS WARREN, M. D.

Supra-Condylloid Amputation of the Thigh by the Method of Gritti.—Dr. W. H. A. Jacobson describes in Guy's Hospital Reports for 1878 two operations performed in this way. Gritti's method is for the knee-joint what Pirogoff's is for the ankle. The femur is sawn through the condyles, and the articular surface of the patella having been removed by the saw, the two divided bone surfaces are brought into apposition. There is some difficulty in bringing the bones together, and accordingly Dr. Stokes, of Dublin, invented the supra-condylloid method, which merely amounts to cutting the bone a little higher up, so that the patella falls down more easily over the end of it. If it does not lie closely to the bone, it may be held in place by a catgut suture passed through

¹ Concluded from page 531.

the periosteum of the posterior cut edge of the femur to the covering at the lower edge of the patella. The incision for the flap begins an inch above and behind the internal condyle, and is carried down vertically to a point opposite the tuberosity of the tibia, then across and up to a corresponding point over the external condyle. There is a short posterior flap. Among the special advantages claimed for this method is the preservation of the normal attachment of the extensor muscle. In one case, however, we find this was divided. The most important advantage is said to be the facility with which an artificial limb is fitted to the stump. This is not too long, as in Gritti's operation, and there is no difficulty in taking the bearing on the end of the stump, which in other amputations is said to become soon so tender that bearing must be taken higher up the thigh. We can see one decided disadvantage in this operation, namely, the sacrifice of the insertion of those muscles of the femur which are attached to the condyles, owing to the height at which the bone is divided.

New Method of performing Amputations. — Professor Verneuil has experimented largely of late years in attempts to overcome some of the difficulties which surround these operations and entail the presence of more assistants than frequently it is possible to obtain. The method he has adopted appears to be based upon the plan usually employed in the removal of large growths, namely, to dissect cautiously with the knife, tying all vessels of considerable size before or as soon as they are divided. The advantages of this plan are illustrated in a case of disarticulation at the hip-joint,¹ which was performed in the following manner: Esmarch's bandage having been applied, and the limb emptied of blood as thoroughly as possible, an incision was made beginning at Poupert's ligament, and, following the line of the vessels for a distance of six centimetres from this point, it was continued at right angles outward and downward, running through the gluteal fold behind, and coming up on the inside two fingers' breadth from the genito-crural fold to the starting-point of the circular cut. All cut vessels were then tied. The next step was the opening of the sheath of the vessels and exposing the femoral at the point where the profunda was given off. The vessel was tied above the division, and two ligatures were also placed below this point. The femoral vein was carefully divided in the same way. The muscles in front and on both sides were then divided one by one, all vessels being tied as fast as cut, the posterior muscles being divided last of all. The disarticulation is affected by an incision through the capsule in front. The patient was fifty-one years of age, and the disease was apparently a myxo-sarcoma of the thigh. The loss of blood appears to have been considerable, — six hundred grammes. The patient recovered. This method appears unsurgical, but might be useful in cases where the surgeon was "short-handed."

¹ Gazette des Hôpitaux, No. 139, 1877. Centralblatt für Chirurgie, No. 22, 1878.

Gastrostomy in Stricture of the Esophagus.—A very successful and satisfactory instance of this operation, performed by Dr. Trendelenburg, of Rostock, Germany, is reported by Dr. Thomson.¹ The patient was a boy nine years of age, who produced stricture by swallowing a draught of sulphuric acid. Neglect of treatment soon rendered the stricture impassable, and all attempts to dilate it having failed the operation was performed. It is thus described:—

“The skin was cut through for a length of four to five centimetres (about two inches) in a diagonal direction, running from right to left, parallel with the under side of the cartilaginous portion of the eighth left rib, and at a distance of a finger's breadth from it. The wall of the abdomen was divided in the same direction as far as the peritonæum, and the left rectus at the same time cut partly through. All the vessels were then carefully bound up, and after the bleeding had entirely stopped the peritonæum was divided in the same direction. The edge of the left lobe of the liver was then exposed to view, rising and falling with the respiration, and also a piece of intestine, which might have belonged either to the colon or to the stomach. As it could not be decided, by feeling about with the introduced finger, to which of these it was attached, I next pulled the diaphragm to the front, and could then easily find the junction of the same at the colon and at the stomach. The peculiar construction of the arteria and vena gastro-epiploica made the junction of the diaphragm at the stomach so characteristic that all doubt disappeared as soon as these vessels were exposed to view. The stomach had shrunk together and attached itself to the vertebral column. Its front side was now grasped at a point corresponding the best with the incision, drawn somewhat forward out of the opening, and fixed temporarily in the opening by two acupuncture needles stuck through it transversely. The two needles rested crosswise on the outer surface of the abdomen. In order that the peritonæum should with certainty be included in the sewing up, the edge of it, where cut, was grasped with pincettes, and was drawn forward and secured by laying the pincettes over on one side. For the stitching moderately strong silk was used, and the stitches were so arranged that the outer skin, the wall of the abdomen, and the peritonæum were pierced, and the wall of the stomach taken up as much as possible in its entire thickness. Altogether fourteen stitches were made. After the sewing, which surrounded a piece of the stomach wall in the form of a circle about one and a half centimetres (five eighths of an inch) in diameter, was completed, the stomach wall was cut through within this circle crosswise, and a drain-pipe inserted in the stomach.”

One of the difficulties of these cases appears to be the tendency of the stomach to tear away from the abdominal wall, and in this respect differs

¹ The Lancet, August 31, 1878.

from cases of enterotomy, where the intestine presses against the wall and shuts off automatically the abdominal cavity. This difficulty is increased when vomiting occurs. Soon after the operation in this case a feverish catarrh of the stomach and intestine appeared, and continued in various degrees for several months. The food, consisting of meat scrapings, soft-boiled eggs, milk, Nestler's children's food, etc., was introduced by means of a syringe into the stomach at intervals of three hours; the meat was first chewed and spit out again. When, however, this method of introducing the food was replaced by a cleaner and more natural one, the stomach catarrh disappeared. A longer tube was attached to the drain-pipe, and through this the boy now lets the masticated food slide down direct into the stomach, which he assists by blowing slightly with the mouth. The boy soon learned to be quite at ease with his artificial œsophagus. In feeding, the œsophagus is removed to the outside; otherwise the process is as much as possible like the natural one. The boy takes his food as before. The masticated and salivated matter remains partly in his mouth and is partly swallowed down into the œsophagus, after which he places the tube in his mouth, and sends the food, by a slight choking and spitting motion, into the tube, and lets it glide down into the stomach, assisting it by blowing slightly with the mouth. Then he shuts the pinch-cock, which he had previously opened, and recommences the process afresh. In this manner the boy is made independent of the highly unappetizing and comfortless procedure of the stomach syringe, and his feeding loses the disagreeable aspect of a physiological experiment.

THE PHILADELPHIA PATHOLOGICAL SOCIETY.¹

THE PATHOLOGY OF STRICTURE OF THE URETHRA.

THURSDAY evening, September 26, 1878, the president, Dr. H. Lenox Hodge in the chair. Dr. John H. Brinton opened the discussion by exhibiting specimens from six fatal cases of stricture of the urethra.

CASE I. A man, thirty-seven years of age, in whose case the parts had first been stretched, and internal urethrotomy then performed. A well-marked attack of urethral fever followed the introduction of the catheter several days after the operation, accompanied by vomiting and suppression of urine. The patient died on the fifth day. The autopsy showed the kidneys to be large and congested; an old, false passage running from a point one inch in front of, to a point two inches behind, the stricture; great congestion of the prostatic sinus, in the near neighborhood of which there was an almond-sized cavity filled with pus; bladder slightly congested; neighboring veins in a highly phlebitic condition; phlebitis the evident cause of death.

CASE II. Internal urethrotomy performed, followed by introduction of No. 10 Thompson sound. Death on the forty-third day; bladder hypertrophied

¹ Reported for the JOURNAL.

and contracted, scarcely holding two fluid ounces of urine; stricture entirely healed; death caused by multiple abscesses of both kidneys.

CASE III. Stricture dilated gradually; no operation performed. Death on thirty-seventh day; bladder full of pus; false passage; death caused by severe pyelitis.

CASE IV. Stricture dilated; no operation performed. Kidneys dilated and congested; bladder contracted and lined with tubercular deposits; large urinary abscess reaching nearly to the fundus of the bladder; all urine passed through a fistula; death on the fifth day, caused by inflammation of the lungs.

CASE V. Stricture dilated by Holt's instrument. Kidneys full of multilocular cysts. Death on forty-seventh day, due to this cystic disease of kidneys.

CASE VI. Meatus cut and stricture dilated at three o'clock in the afternoon; surgical fever entirely controlled by opium and quinine. The man turned over in bed, and died without a groan at six o'clock on the following morning. A careful autopsy disclosed no disease whatsoever of any of the internal organs.

In commenting upon the above cases, Dr. Brinton said that all the deaths had occurred in his hospital practice; that he had never lost a single case in private practice; that he had been able, by carefully tabulating all his cases, to reach the same conclusion drawn by Sir Henry Thompson, namely, that two thirds of all strictures are to be found in the bulbo-membranous portion of the urethra; that in a total of sixty-eight cases of stricture following gonorrhœa the average period elapsing between the time of gonorrhœal infection and the appearance of the stricture had been found to be from five to seven years. The doctor further stated that urethral fever appeared in three out of a total of seven cases in which divulsion and urethrotomy had been performed; in all of the cases in which internal urethrotomy had been employed, namely, four; in eight out of a total of twelve cases where divulsion after Holt's method had been used; in all of the cases of perineal section, namely, four; and in eight out of a total of twenty-two cases where gradual dilatation was employed.

Dr. Samuel W. Gross had paid much attention lately to the subject under discussion, and wished to call attention to the fact that in cases of stricture where other portions of the genito-urinary apparatus were involved any operation, no matter how slight it might be, in hospital practice was likely to be followed by death; that patients entering the hospitals with venereal diseases and stricture were, as a usual thing, entirely broken down in constitution before applying for medical aid; that in such cases he had known death to follow the passage of a catheter. He wished to call attention further to the fact that only the most gentle methods of treatment had been employed in Dr. Brinton's cases, and that what seemed to be a very ghastly showing was due simply to the causes which he had just pointed out.

In his case, as in Dr. Brinton's, the results of private practice had been altogether different, but of twenty-five hospital cases he had had three deaths following internal urethrotomy, and one death following divulsion; whereas in a total of seventy-six cases in private practice, in forty-seven of which he had performed internal urethrotomy, and in twenty-nine divulsion, he had not lost

a single case. He said that he always gave a full dose of quinia before attempting any operation on the urethra, and after the operation injected a good quantity of morphia under the skin. He stated that of the four fatal cases in his hospital practice one death had been caused by pyæmia, and in the other three cases a post-mortem examination had shown the kidneys to be granular and contracted; that no albumen or tube casts had been found in the urine of any of these patients.

Dr. Gross's results differed somewhat from those reached by Dr. Brinton and Sir Henry Thompson; in only about forty-six per cent. of his cases had the stricture been located in the bulbo-membranous portion of the urethra. He desired to lay particular stress upon the following conclusions which had forced themselves upon him, namely: first, that when a stricture is found in the glandular portion of the urethra there will almost always be another further back; second, that protracted gonorrhœa was the most frequent cause of stricture; third, that divulsion and perineal section were the worst of all the operations for the relief of stricture; and, fourth, that in his experience most of the cases of urethral fever were found to follow the operation for internal urethrotomy.

In closing Dr. Gross wished to state as his positive conviction that gradual dilatation was only a palliative means of treatment, and that a stricture could never be permanently cured except by cutting it; that before performing internal urethrotomy, however, he always made it a rule to put his patient through a course of what might be called gradual dilatation.

Dr. Charles W. Hunter wished to know whether urethral fever always occurred after the passage of the catheter, as some authorities held.

Dr. Brinton replied that he placed no confidence upon such statements; that in his practice urethral fever had occurred irrespective of catheterism altogether, in some cases before and in others after the introduction of the catheter.

Dr. Hunter wished to know if stricture had ever reappeared in Dr. Gross's experience after internal urethrotomy.

Dr. Gross said that it had been impossible to follow up most of his cases, but that in those few which he had kept in view there had been no return of the stricture.

Dr. O'Hara desired to inquire as to the means of determining whether a fever were urethral or not.

Dr. Brinton, in answer, detailed the symptoms of urethral fever, — the chill, the profuse sweating, the rapid pulse, etc., — and said that if fever appeared five or six hours after operation it was generally of purely nervous origin; if twenty-four hours after the operation it was in all probability urethral fever; and if as late as seventy-two hours after operating it was, without doubt, pyæmic in nature.

Dr. Charles B. Nancrede related a case in his practice in which complete cure had followed internal urethrotomy. Dr. Brinton also mentioned several cases.

Dr. Hunter had never employed any method for the cure of stricture but that by gradual dilatation at the University Hospital, and had never as yet known of a single case permanently cured. He wished to inquire into the

rationale of internal urethrotomy. Why was it that cutting the stricture did any good? He thought that the tendency of all cicatrices was to contract steadily. He certainly knew this to be so in the case of burns of the skin.

Dr. Gross was aware that cicatrices contracted steadily as a general rule, but said that this was not the case in the operation for division of a stricture and for this reason: he never allowed the sides of the wound to heal together, but forced them to heal by granulation by the daily introduction of bougies of large calibre thoroughly distending the parts. That in this way instead of a constantly contracting cicatrix he was able to add a new fold of mucous membrane to the calibre of the stricture, — a fold equal in length to the combined width of the sides of the cut.

Dr. Edward O. Shakespeare had quite recently, in company with Drs. D. Hayes Agnew and I. Henry C. Simes, examined under the microscope sections from several cicatrices following the operation of internal urethrotomy, and in every instance had found a large preponderance of elastic fibres in the stricture of the cicatrix; in one instance as much as seventy-five per cent. of its bulk being composed of elastic fibres. It was thus plain that cicatrices of the mucous membrane of the urethra were different from those of the skin, since there was always a large preponderance of fibrous tissue in the latter.

Dr. I. H. C. Simes confirmed Dr. Shakespeare in the above statement of the results of his investigations.

Dr. Charles B. Nancrede called the attention of the society to the extreme value of this discovery, and said that Sir Henry Thompson in his most recent publications had denied the existence of elastic tissue in urethral cicatrices.

The president, Dr. H. Lenox Hodge, wished to dwell upon one fact which he thought had been overlooked in the discussion, namely, that proper significance had not been laid upon the almost universal and necessary implication of other organs in stricture of the urethra as an element always of possible fatality in the diagnosis, not only in hospital cases, but also in private practice. Dr. Hodge could remember one case in his own practice in which entire cure had followed gradual dilatation of a stricture.

Dr. Carl Seiler thought that there was always less contraction in a cicatrix of the mucous membranes of the body than in one of the epidermis.

Dr. Hunter in opposition to this statement instanced a case of a child who had swallowed sulphuric acid, the calibre of whose œsophagus had been entirely obliterated, causing death by starvation.

Dr. Shakespeare was sorry that he could not agree with Dr. Seiler's statement.

GRAY'S ANATOMY.¹

THIS well-known text-book has always been a favorite in American schools. The number of the illustrations, their clearness, the plan of printing the names of the parts directly upon their representations, are features that appear to

¹ *Anatomy, Descriptive and Surgical.* By HENRY GRAY, F. R. S. With an Introduction on General Anatomy and Development by T. HOLMES, M. A. A new American from the eighth English edition. To which is added Landmarks, Medical and Surgical, by LUTHER HOLDEN, F. R. C. S. Philadelphia: Henry C. Lea. 1878.

atone for many deficiencies and some inaccuracies in the text. The chapters on surgical anatomy, out of place as they are, prove, no doubt, attractive to students. The volume before us differs, we believe, considerably from the preceding American edition. About one hundred pages at the beginning are devoted to histology and embryology, and the publishers have appended Holden's excellent Medical and Surgical Landmarks. In spite of these advantages we regret that we do not think the book worthy of the position it will occupy. Our ideas of the plan of such a work may, of course, be wrong, but our criticisms on its execution admit of demonstration.

If besides gross anatomy the work includes histology, we have a right to expect something more than a mere sketch. It is proper that the newest discoveries should be utilized, and that the recent views of distinguished observers should at least be referred to in fine type. The science of embryology being yet in its infancy calls for less extensive treatment; we would only demand a clear and systematic account of the chief phenomena, with references to special investigations.

Let us now see how the book before us fulfills these requirements. It opens with a treatise on histology by Mr. T. Holmes, which cannot be called better than very poor. The author appears quite unequal to his task, and as we never heard of him as a histologist we cannot conceive why he undertook it. The account of connective tissue is decidedly behind the times, and, in spite of some efforts to renovate it, gives on the whole a wrong impression. The relations of the cells and the origin of lymphatics — points of vital importance — are made by no means clear, and the cells of tendon do not receive even a word. In the section of histology we find Lockhart Clarke's observations on the structure of the cerebral convolutions, but nothing concerning the minute anatomy of the cerebellum. The histology of various organs is given after their coarse anatomy in a subsequent part of the book, but the microscopic appearances of the ovary are barely mentioned, and those of the testis utterly ignored. The section on embryology is rather more satisfactory, though not without serious shortcomings. We are annoyed at seeing the embryo represented in the diagrams illustrating the early stages at the lower part of the circle, when it is the almost universal custom to place it on top. The chronological table of development, taken from Beaunis and Bouchard, is an addition. We wonder what is the authority for the statement, found elsewhere, that "the umbilical cord appears about the end of the fifth month after pregnancy."

We now come to what may be considered the essential part of the work, that which treats of coarse anatomy. The drawings of the bones, as a rule, are good, and the text rather meagre. The account of the vertebræ and the spinal column might with advantage be fuller. The accessory and mammillary processes deserve more attention than they receive. Of all parts of the body the spine seems to us a standing protest against the artificial way in which anatomy is treated. Here is a firm elastic column, part bone, part gristle, supplied with numerous intrinsic muscles, which practically is as much a unit as any organ in the body, yet we must look under different headings for the description of the separate tissues which are so intimately blended, and what is

said of the spine as a whole is, for the most part, scattered. Let this be in parenthesis; for it is not fair to blame an author for not being in advance of his constituents, if we may use the term. Such a man must appear, however, before English anatomy can be made what it should be. In the last edition of Quain we find the sternum and ribs treated of immediately after the spine, which is certainly better than Gray's method of leaving them till after the head. There is no mention of the double temporal ridge, described by Hyrtl, we believe, some seven or eight years ago. The indications of the insertions of muscles on the drawings of the bones are useful, and we must say a word in praise of the attention given to ossification. In the section of articulations we find a good deal that we like, and fail to find some things we should expect. The central part of the intervertebral disks is said to be "occupied by a soft, pulpy, highly elastic substance, of a yellowish color, which rises up considerably above the surrounding level, when the disk is divided horizontally. This substance presents no concentric arrangement, and consists of white fibrous tissue, with cells of variable shape and size interspersed." We were not aware that white fibrous tissue is highly elastic. Luschka's synovial cavities are not alluded to. The physiology of the joints receives a fair amount of attention, and sometimes is very well treated; as instances we may mention the wrist and the hip joints. The importance of the ilio-femoral ligament in maintaining the erect position is duly insisted upon. We are glad to find the action of the round ligament shown by trephining the acetabulum, though we think its importance is somewhat overestimated. The movements of the knee are treated rather superficially. The effect of the greater length of the inner condyle of the femur is not explained. We differ entirely from the author when he states that there is no motion save flexion and extension in the ankle-joint, and we do not believe that when the narrowest, or posterior, part of the articular surface of the astragalus is in the widest or anterior part of the socket, as in pointing the toes, it is possible for the former bone to be squeezed by the malleoli. We need not say a great deal of the muscles. The directions for dissection are, we think, very useful. The most common anomalies are mentioned. We wish a few more were. It annoys us to see Hutchinson's theory of the action of the intercostals still retained. It has been repeatedly disproved, but it seems that we can never hope to get free from it. Nothing is said of the action of the tensor palati on the Eustachian tube. There is no mention of the capsule of Tenon.

The chapters on the central nervous system are by no means what they should be. The minute anatomy of the cord is inconveniently separated from the gross appearances, being put in the section on histology. We question the statement that the central canal terminates in a cul-de-sac half an inch below the calamus scriptorius. It would not do nowadays to ignore the cerebral convolutions, but there is little advantage in the ill-arranged and inaccurate account before us. Here is an example of the description: "The supra-orbital convolution on the under surface of the anterior lobe is well marked." This is all. It will take a remarkable student to recognize it from this description, especially as it is not pointed out in any plate. We are told that "the ascending parietal [posterior central] usually joins the ascending frontal

[anterior central] either above or below." The fact is that they are almost invariably united both above and below. The crowning blunder is found in Figure 358, in which a fissure running parallel to the interparietal is mistaken for the parieto-occipital fissure which separates those lobes. The mistaken fissure, however, does not reach the longitudinal fissure, so the author is reduced to a theory, stated in a foot-note, that the upper end has been bridged over. All this is the more lamentable that in the figure an uncommonly developed parieto-occipital fissure is quite evident in its proper place. The finer anatomy of the interior of the cerebrum is very defective. The lobes of the cerebellum, on the other hand, are remarkably clearly described. We are sorry to find nine pairs of cranial nerves instead of twelve. The position of the stomach is incorrectly given, and the way in which the structure of the mucous membrane is neglected is really too bad. After mentioning the situation of the mucous glands, and stating that they are lined throughout with columnar epithelium, the author continues as follows: "In other parts of the organ the deep part of each tube is filled with nuclei and a mass of granules; above these are a mass of nucleated cells, the upper fourth of the tube being lined with columnar epithelium. These are called the *peptic glands*, and are the supposed agents in the secretion of the gastric juice." We should have expected a cut of these interesting glands, but it is only natural that the author of such a description should think illustration superfluous. Dr. Watney's researches on the structure of the intestinal villi are quoted, but there is no mention of either Meissner's or Auerbach's plexus of nerves. There is a very pretty cut showing the minute ramifications of the bile ducts between the cells of the liver, but the text is rather obscure as to which of the various opinions of the origin of the ducts is to be accepted. This is excusable, but we should expect a definite statement that they begin within the lobules. After so much fault-finding we must not omit to praise the chapter on the kidney, — rather a left-handed compliment, however, as it is written by Mr. Spitta.

We have nothing to say against the chapters on surgical anatomy and the sections on ligation of arteries, except that we fail to see any reason for their appearance in this work. Anatomy is one thing and surgery is another, and topographical or applied anatomy, which we wish we saw more of, is not necessarily surgical anatomy. We think it very right that the author of a work on anatomy should point out how an anomalous muscle or blood-vessel may interfere with an operation, but it is entirely out of place for him to detail the successive steps of any operation. If the book is meant for a treatise on surgery as well as on anatomy, why do we have no directions for resections and amputations? On the other hand, we are glad to find Holden's Landmarks appended. It would be easy to mention other points worthy of praise and of criticism, but enough, perhaps more than enough, has been written to show our opinion of the work. There are so many good points in the book that it is doubly to be regretted that its faults and deficiencies keep it below the mark that a text-book should reach.

T. D.

A STRIKING CONTRAST.

At the risk of inflicting upon our readers an overdose of views upon medical education, we take the liberty, indeed we feel compelled, to notice a recent contribution to the literature of this subject by a prominent teacher in one of the New York schools, delivered before the American Academy of Medicine, and an almost simultaneous address delivered by a distinguished London scientist to the medical department of the University College. Dr. Frank H. Hamilton's opinions on this subject, coming as they do from a representative of one of a group of schools which have thus far done nothing in the cause of reform, would naturally be read with much interest. One might hope to find at last, now that New York has spoken, some indication in our great centre of clinical instruction of a movement to abandon their old and evil ways and follow the example which has already been set them by more progressive bodies. On the contrary, although we find the "American system" unstintingly condemned, we look in vain for any indication that our learned colleague proposes to bestir himself in the matter. The evil is apparent, but we are hardly to blame for it, he thinks; it is an inheritance received from the mother country; our system of government does not admit our hoping or indeed desiring support from that quarter; private endowment is the only way of enabling our schools to give as high a grade of education as is demanded in other countries. He has seen men in the course of his experience "who thought they were going to revolutionize and reform this whole matter," but after ineffectual struggles they are to-day "as quiet as the dead." *He* is evidently too old a bird to be enticed into any such quixotic performances!

What has he to say of those colleges which have succeeded? Harvard has, after considerable hesitation, adopted some of the needed reforms, but its steps are "slow and unequal." Again: "In according to the University of Pennsylvania, also, praise for its recent action, we must not imagine that she has been actuated by a higher sense of duty or a better code of morals than has hitherto actuated her own board, or than continues to control the conduct of her sister colleges." From beginning to end this address is apologetic in its tone for the old system, while refraining to accord merit to those who have abandoned the same, and gives no hope of any change in the policy of those councils where its author wields great influence. Turning from this unsavory picture, let us see what an Englishman has to say of *his* country in regard to this matter. Among the introductory addresses delivered last month in London was that of Professor Lankester, who gives a graphic sketch of the present condition of medical education in Great Britain. In London particularly the system seems to be inferior to that of Dublin or Edinburgh; no true university exists with all the facilities for giving instruction in the various branches of medical science. There is a large number of hospitals containing the finest clinical material perhaps in the world, but their advantages are frittered away in the interest of numerous small schools, where the teachers consist chiefly of men who occupy their posts at indifferent salaries, with the hope of future promotion to hospital service. At the great universities of England matters are still worse. Both at Oxford and Cambridge medical professorships have been

endowed from time to time, but the control of these institutions was so kept by the clerical party in their own interests that large sums of money have been diverted from the purposes for which they were originally intended, and the teaching of medicine at Oxford has finally ceased altogether, while it is only barely kept alive at Cambridge by the energy of one or two men. In London, as well as at the universities, large funds are in existence on which medicine has a claim, but from which it enjoys no advantages. In contrast with this is the great university of Heidelberg, with its rich endowments; its hospital, laboratories, and lecture-room; its faculty, including such names as Czerny, Kühne, Arnold, and Gegenbauer, whose anatomical institute has no rival in Europe; and all this in a city of only twenty-three thousand inhabitants. Professor Lankester bluntly says: "It is a disgrace to English civilization that a true university, an endowed university, a university in which new knowledge is continually being produced, and in which men are trained for this work of production as the work of their lives, does not exist in London and in each of our large cities."

Is he content to fold his hands and leave matters as they are? By no means. He uses all the influence of his position and name to urge upon the London schools to combine and form a university similar to those of Germany, — the clinical teaching of the hospitals being left as at present, independent of any university organization. The details of this scheme having been given, he eloquently beseeches "every man who enters upon a medical career to remember that he is joining the cause of a profession deprived of its heritage, and to make it his business to reinstate medicine in her seat, and to secure the restitution of her possessions."

Until this is done England must be content, as she herself confesses, to see all English-speaking students of other countries overcoming the disadvantages of a foreign language to study at the Continental schools in preference to her own. And we may add that New York, with clinical opportunities second to no city in the world, with teachers of a world-wide reputation, must be content to see her schools looked upon with contempt until she has placed them upon a footing which modern civilization demands.

SURGEON-GENERAL OF THE NAVY.

UNUSUAL interest has been felt by the medical corps of the navy in the appointment of a "chief of the Bureau of Medicine and Surgery" in the Navy Department at Washington; the late incumbent, Surgeon William Grier, having recently retired by reason of age.

The Bureau of Medicine and Surgery, next that of Docks and Yards, is the most important of the departmental bureaus, and an appointment as its chief carries with the office the relative rank and pay of a commodore, and the title of "surgeon-general of the navy." With but a single exception it has always been given to the senior surgeon on the active list, and the importance attached to the present selection of this official has grown out of the fact that the secretary of the navy, on account of the comparatively brief time remain-

ing before the officer whose name headed the list would be retired by reason of age, has seemed disposed to disregard precedent, and appoint to the vacant position a junior member of the medical corps. Great satisfaction is therefore felt that the head of the department has adhered to a custom, the non-observance of which would have had so demoralizing an influence.

Medical Director J. Winthrop Taylor, upon whom the surgeon-generalship has been conferred, was born in New York, in 1817. Graduating from Princeton College, and from the medical department of the University of Pennsylvania, he was appointed to the United States navy from the State of New Jersey in 1838. He has spent sixteen years and seven months at sea, an amount of service which has been equaled by but two other medical officers of the active list. He was in active duty throughout the Mexican war and the rebellion. He accompanied the expedition sent to bring the filibuster General Walker away from Nicaragua, and commanded in person the detail which conducted the prisoner by a long and perilous journey to the coast. He was surgeon of the *Pensacola*, when she ran the blockade of rebel forts erected along the Potomac River for her destruction, and was on duty in the same ship when, under Farragut, she passed the Mississippi forts, and assisted in the capture of New Orleans.

Surgeon-General Taylor has resided for many years in Boston, having been repeatedly attached to the Navy Yard, the *Rendezvous*, and the receiving ship at Charlestown, and to the Naval Hospital at Chelsea. This crowning honor of an active and unblemished service of forty years will give pleasure to a large circle of friends, by whom he is well known for his urbanity and his high standing as an officer and a gentleman.

MEDICAL NOTES.

NEW YORK.

— The numerous medical societies are now once more in active operation, and at the last meeting of the Academy of Medicine (October 17th) an interesting paper entitled *The Problem of Yellow Fever* was read before a large audience by Dr. Octavius White, a gentleman of Southern birth and education, whose name is widely associated with this disease. During the epidemic of 1876 in Savannah he offered his professional services to the afflicted city, and remained actively engaged in combating the pestilence until its final disappearance.

— A movement is now on foot which aims at a union between the Academy of Medicine and the Medical Journal Association, and at the next meeting of the latter a formal proposition to this effect will no doubt be made. It is claimed by those advocating the measure that all the advantages of both societies can thus be secured to members of the profession by the payment of an annual sum of ten dollars; while under the present arrangement gentlemen who belong to both are required to pay twenty dollars a year in dues. For some time past the Journal Association has had its rooms in the Academy's building.

—The committee of citizens having in charge the collection of clothing, etc., for yellow fever sufferers have reported a great success in their undertaking, and have issued a card of thanks to the people of New York for their generous response to their appeal. "Our sub-committees," says the report, "were received on their collection tour with a full-handed cordiality that amounted to a popular demonstration. They began their canvass of the city on Wednesday morning, October 9th, accompanied by a number of wagons liberally contributed by many merchants and companies, and preceded by the American District Telegraph Company's messengers, voluntarily detailed by that efficient organization, and concluded their labors on Friday evening, October 11th. Large quantities of valuable new goods were collected, cloth for suitings, ready-made clothes, shoes, blankets and other bedding, ladies' suits, etc. Messrs. A. T. Stewart & Co. alone contributed over eleven hundred articles of ladies' wear, including a number of entire suits, cloaks, jackets, and waterproofs; and the general average of all the collections was surprisingly good."

The grand total of the collections is estimated to exceed one hundred and fifty thousand dollars in value. Mr. George N. Sanders was the chairman of the general committee, and P. Brynberg Porter, M. D., chairman of the executive committee having the matter in charge.

CHICAGO.

—That distinguished veteran of the profession, Dr. Nathan S. Davis, was, on October 15th, nominated as the democratic candidate for Congress for the district comprising, with other territory, the north division of the city of Chicago. Judge Tree had been nominated and declined, when Dr. Davis was chosen by the central committee. His nomination is surprising, as the district is largely made up of beer-drinking Germans, who abominate unspeakably anything that smacks of the temperance movement, and Dr. Davis has for years been distinguished in Chicago for his bitter warfare upon King Alcohol. He is ultra to the degree of banishing alcohol as a medicine. He has declined the nomination.

—Dr. Aiken, whose application for an injunction to restrain the State Board of Health from revoking his license was last week decided adversely, has now (October 19th), through the State's attorney, filed a petition for an information in the nature of a *quo warranto*, asking that the members of the State Board of Health show by what authority they hold office and do various acts and things they claim the right to do.

—There are three hundred and forty students attending the present session of Rush College.

—The frequency of the occurrence of trichinæ in American bacon has given rise to petitions to the German government for the obligatory inspection of all ham and bacon sold in the various provinces of that country. It has been shown that about one half of one per cent. of American bacon sold in some parts of Germany contains trichinæ, mostly dead, but in certain cases living, in spite of abundant salting and a curing process of three months. In such exceptional cases the living parasites are found in the deeper layers, re-

mote from the surface. The same is true of the portions next to the bone in ham smoked by the so-called rapid process. The "spare-ribs," which are ordinarily very extensively affected when trichinosis is present, are usually sold fresh in this country; but they are, as a rule, thoroughly cooked here, and the outbreaks of disease so common in other countries, due to eating underdone and trichinous swine-flesh, are exceedingly rare.

— By recent act of the legislature the reports of the State Board of Health are to be sold by the secretary of state. A few copies of this year's report are still to be had.

CHILDREN'S HOSPITAL.

SERVICE OF DR. BRADFORD.

[REPORTED BY DR. F. H. DAVENPORT.]

Caries of Ankle; Removal of Astragalus and Scaphoid. — J. M., aged four, has had caries of the right ankle for several months. The sinuses were enlarged, and portions of dead bone removed by Dr. Langmaid. No improvement followed, and it became evident that more carious bone remained, the position of the sinuses and of the swelling indicating that the astragalus was the bone involved.

June 27th. An incision was made on the outer side of the foot, over the head of the astragalus. Both the astragalus and the scaphoid were found diseased, and both of these bones were removed. To facilitate this a straight incision was made on the dorsum of the foot. The other bones of the tarsus were healthy, but the lower edge of the tibia was found slightly roughened, and was scraped.

The operation was done and the limb dressed antiseptically; the dressing was, however, removed in twenty-four hours, as it was found to have leaked badly, and the wound was dressed with oakum and washed with a solution of thymol (one to one thousand).

At the present time, three months after the operation, there is good mobility at the ankle-joint; the incisions have healed, with the exception of the site of the drainage tube, which has been recently removed. The child is able and anxious to stand upon his foot, which is in good shape, and promises to be perfectly useful.

Umbilical Fistula. — F. L., aged four, has been an inmate of the hospital for some time for a congenital umbilical fistula. A small sinus in the centre of the umbilicus secretes a minute quantity of a clear, glairy fluid. This is sufficient to cause a troublesome eczema, which, unless the child is carefully nursed, involves the whole of the belly. No umbilical hernia is present, and there are no superabundant granulations. A sufficient amount of the fluid secreted could not be collected for chemical examination. There was, however, no urinous odor in the compress kept over the sinus. A probe would enter as far as the peritoneal cavity, but the further course could not be determined either by a probe or a capillary bougie.

The tract of the sinus was cauterized by a red-hot knitting-needle, as is

recommended by Mr. Holmes, and then packed with absorbent cotton, in the hope that the granulations would be kept dry, and union result. No improvement, however, followed. As the boy was debarred by his slight infirmity from admission to the Orphan Asylum, more active measures seemed to be demanded.

A director was passed into the sinus, the handle depressed, and the soft parts incised; the whole tract of the sinus was thus laid open, and the skin above incised. The further course of the fistula could not be followed either by means of a probe or a capillary bougie. The edges of the sinus were refreshed, and the skin sewed together. No force was intentionally used in passing the director, but a small portion of the omentum protruded as the child coughed. As it seems improbable that the fistula opened directly into the abdominal cavity, it is more likely that the peritonæum was punctured in passing the director. The operation was done and the wound dressed antiseptically; no inflammatory symptoms followed. The omental hernia increased slightly, granulated, and formed adhesions to the skin, causing a small, pedunculated, granulating tumor. This was tied, and caused no farther trouble. No hernia or tendency to hernia remained. The incision united by first intention. A small opening remained, through which a drop of clear fluid could be forced on pinching up the skin. This, a month after the operation, showed no tendency to heal. [NOTE. A similar case operated upon successfully in a somewhat similar way by Mr. Paget may be found in the *Medico-Chirurgical Transactions*, Tome xlv., 1861.]

Congenital Inguinal Hernia; Operation according to Heaton's Method.—O. F., a child twenty months old, had a congenital inguinal hernia admitting the little finger through the ring. The testicle had descended, and showed no tendency to be drawn up into the abdominal cavity. The intestine protruded whenever the child cried, and descended into the scrotum.

The hernial sac was injected three times, according to Heaton's method, with a preparation of quercus alba, mentioned in his book.

Difficulty was encountered in determining the exact place for "tendinous irritation." The first injection failed, and as the irritant was not deposited on the pillars a second injection likewise failed. Two weeks after a third injection the hernia was found to be held up even when the child cried forcibly. An examination by the finger showed that the opening had diminished to a marked degree, and could not readily be found. No inflammatory symptoms followed either of the injections, except a slight epididymitis after the first, due probably to inexperience in depositing the irritant. After each injection the hernia was kept from protruding by a form of bandage sold by dealers as the rainbow truss.

LETTER FROM PHILADELPHIA.

MR. EDITOR,—The tercentenary of the birth of Harvey has evoked from those who delight to do him honor a considerable addition to the literature of the history of his life and times, and the question of his immortal discovery. Among the many able memorial addresses and essays upon this subject the

latest, though not less in rank than those which have gone before, is one from the facile pen of Professor Da Costa. In his introductory to the winter course of lectures at the Jefferson Medical College, on the evening of October 2, 1878, he announced as his theme "Harvey and his Discovery," and delivered a most interesting lecture, in which he happily presented some important evidence in support of Harvey's claim as the discoverer of the systemic circulation, which has never before been published in this connection. The amphitheatre of the college hospital was densely crowded with a sympathetic and most appreciative audience, which listened for an hour and a half, enchained by the graceful style and elevated expression, and the distinct though fervid delivery of the speaker. A pleasant surprise awaited the professor, for at the end of the discourse one of the students stepped into the arena with a valuable piece of plate, which he presented to the orator in the name of the class in token of their esteem and affection. The customary students' edition of the lecture has been printed by the class, but as Mr. J. B. Lippincott, who considers it a valuable contribution to the subject, intends to publish it in a permanent form, I will not by a more extended notice anticipate its review in regular course in these pages.

Over at the University the new laboratory building was opened on the 4th inst., by Dr. S. Weir Mitchell, who gave an interesting review of the scientific progress of medicine during the last half century, noting particularly the tendency toward the application of apparatus of precision to the study of disease.

The Board of Health of Philadelphia passed resolutions on the 8th inst. cordially indorsing the recent action of Surgeon-General Woodworth in appointing a commission to proceed to the South, and study the causes of the yellow fever, and also appealing to our public-spirited citizens for contributions to the expenses of the inquiry. A number of our prominent physicians have signed a card requesting the citizens to furnish the material aid required, believing that "practical results may be achieved which will materially lessen the possibilities of the recurrence of such visitations with their attendant distress and suffering to the people of the South, and their danger to the health of Northern cities.

At the last meeting of the county medical society an interesting discussion on the subject of the intravenous injection or transfusion of milk, was provoked by a paper presented by Dr. Wm. Pepper, entitled *Functional and Organic Anæmias, and the Use of Milk Transfusion in their Treatment*, which contained the record of two cases in which it was resorted to with benefit. The opinion was generally concurred in that milk possesses the advantages of blood without the disadvantage of forming coagula. Dr. Chas. T. Hunter said that he had performed the operation in hospital and private practice upon twelve cases, and described the method he had pursued. The apparatus consists of (1) a funnel capable of holding about six ounces; this is surrounded by a reservoir containing, at the time of the operation, water at a temperature of 99° to 100°; (2) of a rubber tube about one sixth of an inch in diameter and twenty-four inches long; and (3) of a nickel-plated steel canula about one eighth to one twelfth inch in diameter, and terminating in a sharp or quill point. The last canula he had made has a stop-cock to control the flow. As

the injection is made only by the force of gravity, the rapidity and force of the current is altered at will by elevating or lowering the reservoir. The fresh, warm milk is poured into the funnel, across the top of which is a strainer of finest metallic gauze to intercept any hairs or accidental particles of dirt. The warm water in the reservoir keeps the milk at the proper temperature. The operator having applied a fillet above the elbow, as in phlebotomy, and having made a superficial incision above the vein and isolated the vessel, the sharp point of the canula is thrust into the vein, and the milk allowed to flow, the air having been first displaced by the passage of a small amount of the milk previous to the insertion of the canula. The milk is allowed to flow gradually into the vein until the desired amount is injected; the wound is then brought together with an adhesive strap, and a compress and bandage applied. The median cephalic vein is preferred, but when this is too small the median basilic is taken. The small incision heals by first intention, and in at least one of the cases the blood had resumed its course through the vein on the fourth day. Dr. Hunter objected to the use of carbolic acid in washing out the apparatus unless an alkaline solution is applied immediately afterwards. Every precaution should be used to keep the milk from becoming sour, or dangerous results may follow. The milk should not be strained through ordinary gauze, as flocculi or particles of thread may be washed into the current, and lead to pulmonary embolism. In a case of exhaustion from repeated intestinal hæmorrhages during the later stages of typhoid fever, occurring during the summer in a gentleman of prominence in this city, the patient was unconscious and apparently moribund when the transfusion was performed, which was followed by remarkable effect. The patient revived, and such decided improvement was manifest in less than twelve hours that the injection was repeated. He became conscious, took nourishment well, the passages were fewer in number, and for several days hopes were entertained of his recovery, but the hæmorrhages returned, and he died on the fifth day, of exhaustion. The third transfusion was attempted, but he expired during the operation. In all these latter operations goat's milk was employed. The details of this discussion and Dr. Pepper's paper will appear in regular form in the Proceedings of the Philadelphia County Medical Society, published in the columns of the *Philadelphia Medical Times*.

F. W.

PHILADELPHIA, October 11, 1878.

SHORT COMMUNICATIONS.

A CASE OF IDIOPATHIC TETANUS.

BY FRANK L. SMITH, M. D., STAFFORD SPRINGS, CONN.

WILLIAM C., age twenty-four, nationality Irish, occupation weaver of woolen goods, had never had any serious sickness. I was called to see the patient on the evening of August 17th, and learned the following history: On the preceding Friday, August 9th, the man complained of a cold, with stiffness about the jaws; that he disliked to talk or eat on account of the fatigue caused thereby. He had been working for several days with wet feet, caused by leaky shoes, and attributed the trouble to that. As he became no better, on Sunday, August 11th, a doctor was summoned. The patient was at this time up and about the house, having hop poultices applied to the throat and jaws; he was informed by the doctor

that he was following the proper course. The evening of Friday, the 16th, the writer was summoned. Found the man in bed, with anxious countenance, profuse perspiration, pulse 100, temperature in the axilla 102.5° F., respiration 28, urine normal, and bowels constipated. He was covered with a bright-red rash, which I judged to be the effect of some medicine he had taken. At short intervals he was seized with spasms of pain at the epigastrium, lasting from one to three minutes. The jaws were firmly closed, and any attempt to open them brought on spasm; marked opisthotonos; mind clear; had obtained little sleep for three or four nights. Very careful inquiry and inspection failed to elicit the history of any cut, bruise, or injury whatever; the disease could be referred to no cause. I immediately pronounced the case one of tetanus, and put the man on a drachm of chloral hydrate every two hours, and all the milk he would take.

August 18th, eight A. M. Found the patient more comfortable, sitting up in bed; reported having passed the best night since his sickness commenced; slept considerable; muscular rigidity somewhat relaxed, but unable to open the mouth; pulse 96; temperature 98.6° F. Kept him on the chloral, with generous nourishment.

Seven P. M. Has had a comfortable day. Was moved down-stairs; had to be carried, on account of stiffness of muscles of the back; pulse 100; temperature 100.5° F.

August 19th, eight A. M. Pulse 92; temperature 98.5° F., indicating improvement, notwithstanding which he did not have as comfortable a night; no improvement as regards rigidity of muscles of jaws or back; spasms rather more frequent. Pressed the chloral. Gave him three compound cathartic pills, and added stimulants to his milk. Eruption has disappeared.

Eight P. M. Pulse 100; temperature 100.5° F. Locates a constant pain at one inch below and two inches to the right of navel; point can be covered with the finger tip; no tenderness on pressure; abdominal muscles rigid, with sunken belly. Complains of the chloral "driving the breath out;" no improvement of jaws and back. Gave him one fourth of a grain of elaterium every hour until bowels moved, as injections and pills have had no effect.

August 20th, 7.30 A. M. Pulse 98; temperature 99.6° F. Has not taken his chloral at all regularly through the night; says he cannot swallow it; deglutition very difficult, some of the medicine returning; spasms the same; pain near navel gone; bowels moved after three doses of the elaterium. Substitute one eighth of a grain of morphia every two hours for chloral.

Eight P. M. Pulse 96; temperature 100.6° F. Condition remains unchanged; refuses to take stimulants. Give them by the rectum, and keep perfectly quiet, this having been enjoined at every visit. Continue same treatment.

August 21st, eight A. M. Pulse 108; temperature 99.4° F. Complains of a constant pain at epigastrium, increased during spasm; deglutition difficult; has not taken as much nourishment through the night; very restless; wants his position constantly changed, and when this is attempted it brings on spasm; body perfectly stiff when moved. Continue morphine and stimulants.

Eight P. M. Pulse 108; temperature 101.5° F. More restless; spasms recurring more frequently; takes no nourishment except by rectum; left hand strongly adducted; cannot turn in bed. A foamy saliva is constantly collecting in mouth, blown through the teeth, and wiped away.

August 22d, seven A. M. Pulse 118; temperature 103.6° F. Deglutition very difficult; muscular rigidity becoming more general; spasms excited by attempting to speak or to take liquids, and very frequent when not brought on thus.

Six P. M. Seen with Dr. Cassidy. Pulse 140; temperature 104.8° F. Spasms recurring almost constantly; power of deglutition nearly gone; patient says he shall die. Give him ten drops of Majendie's solution hypodermically, as he complains a great deal of the constant pain at epigastrium. Give injections of whisky and quinine.

At eleven o'clock of the same evening, while giving a half teaspoonful of whisky by the mouth, the patient suddenly began to struggle for breath. Thinking that some of the liquid might have entered the trachea, I turned him on his face with head depressed; the struggles continuing, I turned him back, and found the countenance livid, with blue lips, and in less than a minute all struggles ceased, and the man was dead. The muscles of respiration having been suddenly attacked he was unable to take another breath, and so died, asphyx-

iated. I might add that just at the last, after he was apparently dead, a series of general muscular spasms ensued, constant and very rapid, lasting for perhaps two minutes. No autopsy could be obtained.

I have been led to report the case in detail on account of the extreme rarity of tetanus as an idiopathic affection. Flint in his work on Practice says: "Idiopathic tetanus is everywhere rare, and in cold or temperate climates is one of the rarest of affections." An interesting feature of the case was the extreme frequency of the pulse during a spasm, it running up forty to fifty beats, and as rapidly subsiding when the spasm was over. Again, it will be observed that the temperature followed almost regular fluctuations for three days, being 98° and 100° respectively morning and evening for two days, and the next two 99° and 100°, when it took the sudden rise indicating the approaching end. The bladder was at no time affected, and the urine was normal throughout. The mind was perfectly clear up to the moment of suffocation. The disease lasted fourteen days from the time of the first sensation of stiffness about the jaws.

"NEURALGIA" OF THE EYE.

MR. EDITOR, — It may be premised that glaucoma is rarely recognized by general practitioners. From time to time specialists see persons suffering from this comparatively rare disease who have been treated for neuralgia, of which the following case is an example: Mrs. X., aged fifty-two. Sight dim in the left eye since 1868. In the summer of 1876, as I learned, severe pain, with lachrymation, appeared in both eyes. She received the treatment ordinarily adopted for neuralgia, but with the cessation of the pain the sight also disappeared, so that in December she could "see only across the street."

A year later, when first seen by me, she was totally blind, though she still complained of occasional pain. In both eyes the globe was very hard, pupil dilated, fundus not visible, reflex greenish; in fact, there were present the usual symptoms of absolute glaucoma.

This patient, it is most likely, had chronic glaucoma in her left eye for eight years, which took on an acute form when her right eye became affected. At this time some, at least, of these appearances could probably have been observed: injection of the eyes, with a flow of tears; the sensibility of the corneæ blunted; the irides dilated, perhaps irregular and discolored, and pressed towards the corneæ; and the eyes hard to the touch.

The patient would have complained of severe pain, chiefly at night, in the eyes and in the adjacent parts supplied by the fifth pair of nerves, of weakness of sight, and of seeing the colors of the spectrum arranged like a rainbow on looking at a lighted candle.

Setting aside the ophthalmoscope, by the use of which the diagnosis of glaucoma would have been arrived at, the foregoing symptoms, or as many as were present, were most likely sufficient to have given a clue to the nature of the disease. At that period *immediate operative interference*, instead of attempting to treat the neuralgia, might have saved in a great degree the sight of the patient.

The use of anodyne collyria, especially in their relations to this affection, merits notice. Happily, the old *vinum opii*, if still found in the shops, is now rarely applied to the eye for the quieting of pain. For this purpose it is quite worthless. In its place, but mostly for its mydriatic effect, the sulphate of atropia is at present much employed by general practitioners. In diseases of the iris and cornea its marked anæsthetic action on the ciliary nerves is shown by the relief of pain and intolerance of light that follow its use. Now, in chronic glaucoma where, for example, but one eye is affected, if, for the sake of securing its anodyne effect, a single drop of a 0.1 to 8.0 solution of atropine is instilled in the eye, an attack of acute glaucoma may ensue.

Dr. Hasket Derby and other observers (I can cite one case) have reported instances where, when the presence of this disease was not suspected, it quickly followed the use of this alkaloid. Unless, then, one is certain that the pain, redness, etc., are due to a diseased state of the iris or cornea, it would be well to hesitate before resorting to atropine.

SALEM, September 13, 1878.

Very respectfully,

DAVID COGGIN.

STATISTICS OF THE BOSTON DISPENSARY.

THE following are the statistics of the Boston Dispensary for the year ending September 30, 1878. The number of new patients treated at the central office is 22,694, classified as follows :—

MEDICAL DEPARTMENT.

	Men.	Women.	Children.	Total.
1st quarter	903	1724	1620	4247
2d "	1075	1466	932	3473
3d "	1038	2107	1071	4216
4th "	947	1844	1194	3985
Total	3963	7141	4817	15,921

SURGICAL DEPARTMENT.

	Men.	Women.	Children.	Total.
1st quarter	347	218	140	705
2d "	372	183	151	706
3d "	341	182	162	685
4th "	447	227	192	866
Total	1507	810	645	2962

DENTAL DEPARTMENT.

	Men.	Women.	Children.	Total.
1st quarter	149	232	261	642
2d "	158	176	183	517
3d "	128	168	214	510
4th "	219	179	273	671
Total	654	755	931	2340

SKIN DEPARTMENT.

	Men.	Women.	Children.	Total.
1st quarter	180	179	168	527
2d "	170	108	127	405
3d "	98	109	53	260
4th "	94	86	132	212
Total	542	482	480	1404

DEPARTMENT FOR DISEASES OF THE NERVOUS SYSTEM.

	Men.	Women.	Children.	Total.
1st quarter	12	10	4	26
2d "	9	11	1	21
3d "	10	5	1	16
4th "	2	1	1	4
Total	33	27	7	67

The number of new patients treated in the districts is 17,160, classified as follows :—

	Men.	Women.	Children.	Total.
1st quarter	624	1456	2291	4371
2d "	559	1619	2078	4256
3d "	479	1216	3102	4797
4th "	530	1271	1933	3736
Total	2192	5562	9406	17,160

The results of treatment are as follows :—

Discharged, cured, or relieved	16,144
Sent to hospitals or removed from districts	519
Died	525
Remaining under treatment	99
	<hr/>
	17,287
Remaining under treatment at last annual report	127
	<hr/>
	17,160
Number of cases treated at the central office	22,694
	<hr/>
Total number of cases treated at the central office and in the districts	39,854
Whole number of patients treated since October, 1796	695,432
Whole number of patients treated since July, 1856	576,630
Average daily attendance at central office during the year	169+

Superintendent, William H. H. Hastings, M. D.

Surgeons, Thomas Waterman, M. D., Charles E. Inches, M. D., Water Ela, M. D., E. H. Bradford, M. D.

Physicians: R. Disbrow, M. D., R. H. Fitz, M. D., J. L. Hale, M. D., W. H. Baker, M. D., J. P. Oliver, M. D., A. M. Sumner, M. D., W. C. Holyoke, M. D., G. B. Shattuck, M. D., R. M. Lawrence, M. D., J. Dixwell, M. D., J. B. Ayer, M. D., J. F. Bush, M. D., F. H. Davenport, M. D., Abner Post, M. D., T. M. Rotch, M. D., M. H. Richardson, M. D.

Department for Diseases of the Nervous System. Physicians: D. F. Lincoln, M. D., F. W. Vogel, M. D.

Department for Diseases of the Skin. Physician: F. B. Greenough, M. D.

Dental Department. Dentist: F. E. Bunfield.

District Physicians: No. 1, G. W. Copeland, M. D.; No. 2, C. M. Jones, M. D.; No. 3, E. F. Hodges, M. D.; No. 4, E. C. Booth, M. D.; No. 5, S. Howe, M. D.; No. 6, A. T. Cabot, M. D.; No. 7, W. F. Whitney, M. D.; No. 8, W. J. G. Fogg, M. D.; No. 9, T. G. Reed, M. D.

Apothecary: F. H. Clark.

ABSTRACT OF SANITARY REPORTS RECEIVED DURING THE PAST WEEK UNDER THE NATIONAL QUARANTINE ACT.—No. XVI

OFFICE SURGEON-GENERAL U. S. M. H. S., WASHINGTON, October 26, 1878.

NEW ORLEANS, LA. — During the week ended yesterday evening there were 699 cases of yellow fever and 229 deaths. Total cases 12,881, deaths 3864.

PLAQUEMINE, LA. — Total cases of yellow fever to October 20th 1159, total deaths 125.

BATON ROUGE, LA. — For the past week there were 170 cases of yellow fever and 15 deaths. Total cases 2340, deaths 144.

MORGAN CITY, LA. — There were seven deaths from yellow fever during the past week. Total cases to date 510, deaths 94.

PORT HUDSON, LA. — Report to October 20th gives total cases of yellow fever 75, total deaths 10, including four resident physicians. The first case of the fever occurred September 9th, first death September 13th.

MOBILE, ALA. — There were 71 new cases of yellow fever and 17 deaths during the week ended yesterday evening. Total cases 164, deaths 49.

OCEAN SPRINGS, MISS. — No deaths from yellow fever during the week ended at noon yesterday. There were eight new cases in Ocean Springs, and nine cases in the country not previously reported. Total cases 145, deaths 29.

PASS CHRISTIAN, MISS. — For the past week there were 44 cases of yellow fever and five deaths. Total cases 170, deaths 18.

WATER VALLEY, MISS. — Total cases of yellow fever to yesterday evening 146, total deaths 60. Six new cases yesterday.

PORT GIBSON, MISS. — The yellow fever has spread into the country. As near as could be ascertained about 30 deaths occurred in the past week. The colored people in the country repel the friendly aid offered them, for fear of having the yellow fever brought to them by nurses, while they are dying from it without knowing that it is yellow fever.

HUDSON, LA. — To October 13th there had been 75 cases of yellow fever and 18 deaths.

GERMANTOWN, TENN. — The first case of yellow fever occurred August 20th. First case among inhabitants August 25th. Total cases to noon October 16th 65, deaths 36.

MEMPHIS, TENN. — For the week ended the evening of the 24th inst., there were 50 deaths from yellow fever. Total deaths 2942.

BROWNSVILLE, TENN. — During the week ended yesterday evening there were 16 deaths. Total cases 560, deaths 152.

CHATTANOOGA, TENN. — For the past week there were 80 cases of yellow fever, and 23 deaths. Of these 51 cases and nine deaths were among colored people.

ST. LOUIS, MO. — At quarantine during the past week three residents were admitted and died of yellow fever. One patient previously reported also died of yellow fever.

CAIRO, ILL. — For the two weeks ended yesterday evening there were 44 cases of yellow fever, and six doubtful cases. Deaths for the same period 16. Total cases 75, deaths 41.

LOUISVILLE, KY. — There were four new cases of yellow fever for the week ended yesterday evening, and seven deaths. Total cases 131, deaths 61, including refugees.

CINCINNATI, OHIO. — No new cases of yellow fever during past three weeks; one death reported for the past week.

DECATUR, ALA. — During the week ended yesterday evening there were 23 new cases of yellow fever, and 13 deaths. Total cases 178, deaths 40.

BILOXI, MISS. — Up to October 17th there were 295 cases of yellow fever, and 40 deaths.

GREENVILLE, MISS. — To noon of October 11th there were 301 deaths from yellow fever, 21 of which were in the country outside of Greenville.

HERNANDO, MISS. — During the week ended yesterday evening there were 32 cases of yellow fever and seven deaths. Total cases 165, deaths 63.

No cases of yellow fever or deaths during the past week at PORT EADS, LA., SOUTH WEST PASS, LA., and KEY WEST, FLA.

HAVANA, CUBA. — Twenty-three deaths from yellow fever, and one from small-pox, for the week ended October 19th.

Deaths from four preventable diseases reported for the week ended October 19th: —

Enteric fever. — In Baltimore five deaths, Boston two, Brooklyn two, Charleston three, Cleveland one, Philadelphia nine, Richmond one.

Typhus fever. — One death in Brooklyn.

Scarlet fever. — In Baltimore six deaths, Brooklyn five, Cincinnati 14, Cleveland two, Philadelphia 13, Richmond one.

Diphtheria. — In Baltimore six deaths, Boston 14, Brooklyn 15, Charleston two, Cleveland 13, New Haven five, Philadelphia 13, Richmond two.

GREAT BRITAIN. — During the week ended October 5th there 3409 deaths in twenty-three large cities of the United Kingdom. The mortality was at the average rate of 21 annually per 1000 of the population. In Brighton the rate was 14, the lowest; in Liverpool 28, the highest. In the same cities, not including Edinburgh, there occurred 11 deaths from small-pox, 161 from scarlet fever, and 33 from diphtheria.

PARIS, FRANCE. — There were 30 deaths from enteric fever during the week ended October 3d. The annual rate of mortality per 1000 of the population, based on weekly mortality, was 22.5.

No deaths from cholera in Calcutta for the week ended August 24th, and none in Bombay for the week ended September 3d.

No reports received from the following places where yellow fever exists: Vicksburg, Miss.; Holly Springs, Miss.; Canton, Miss.; Grenada, Miss.; Bay St. Louis, Miss.; Friar's Point, Miss.; Mississippi City, Miss.; Spring Hill, Miss.; Crystal Springs, Miss.; Hickman, Ky.; Grand Junction, Tenn.; Paris, Tenn.

JOHN M. WOODWORTH,
Surgeon-General U. S. Marine Hospital Service.

ALCOHOL AS A LOCAL APPLICATION IN WOUNDS.

In the spring of 1862, Professor Pancoast, of Philadelphia, removed a small tumor from my neck, and applied his styptic to the wound. There was very sharp smarting for a minute or two, when the wound was closed. Dr. Pancoast claimed that this checked bleeding from the small vessels and otherwise promoted the healing process. The recipe is as follows:—

R ^y Castile soap	3i.
Bicarb. potass.	3ij.
Alcohol	3iv. M.

Apply with pledgets of lint.

I should think there would be but little difference, if any, between the therapeutic effect of this and that of pure alcohol as recommended by Professor Gosselin. See *JOURNAL, courant*, page 369.

J. O. WHITNEY.

PAWTUCKET, R. I., September 21, 1878.

BOSTON SOCIETY FOR MEDICAL OBSERVATION.—The next meeting of the society will be held at the rooms on Temple Place on Monday evening next at eight o'clock. As business of importance will come before the society a full attendance is desired.

MEDICAL LIBRARY ASSOCIATION.—The Library has moved to its new house, No. 19 Boylston Place.

ERRATUM.—In the thirteenth line of page 532, for "indignant" read "malignant."

BOOKS AND PAMPHLETS RECEIVED.—The Nature and Treatment of Inebriety. Also, The Opium Habit and its Treatment. By Dr. Edward C. Mann. New York: Charles A. Coffin. 1878.

The Principles and Practice of Surgery. A Treatise on Surgical Diseases and Injuries. Vol. I. By D. Hayes Agnew, M. D., LL. D., Professor of Surgery in the Medical Department of the University of Pennsylvania. Philadelphia: J. B. Lippincott & Co. 1878.

The Duties of the Medical Profession concerning Prostitution and its Allied Vices. An oration delivered before the Maine Medical Association. By Frederick Henry Gerrish, M. D., Professor of Materia Medica, etc., in Bowdoin College. Portland: Loring, Short and Harmon. 1878.

Treatment of Fracture of the Shaft of the Femur. The "American Method." A paper read before the Minnesota State Medical Society. By Franklin Staples, M. D., of Winona. St. Paul: H. M. Smith & Co. 1878.

On the Use of the Solid Rubber Bandage in the Treatment of Eczema and Ulcers of the Leg, and On Diet and Hygiene in Diseases of the Skin. Two pamphlets by L. Duncan Bulkley, A. M., M. D., Physician to Skin Department, Demilt Dispensary, New York. New York: G. P. Putnam's Sons. 1878.

Communicable Diseases of Childhood, and some Suggestions for their Prevention. By Henry R. Baldwin, M. D. Newark, N. J.: L. J. Hardham, Printer.

The Cell Doctrine: Its History and Present State. For the Use of Students in Medicine and Dentistry. Also a copious bibliography of the subject. By James Tyson, M. D. Second Edition. Philadelphia: Lindsay and Blakiston. 1878. (A. Williams & Co.)